

MN Health Care Reform Task Force

DRAFT Minutes—July 12, 2012 - Revised

Task Force Members Present

Peter Benner (Former AFSCME), Senator Michelle Benson, Michael Connelly (Xcel Energy), Commissioner Ed Ehlinger (MDH), MayKao Hang (Amherst H. Wilder Foundation), Commissioner Lucinda Jesson (DHS) - CHAIR, Jan Malcolm (Courage Center), Ralonda Mason (St. Cloud Area Legal Services), Commissioner Mike Rothman (Commerce), Judy Russell-Martin (MN Nurses Association), Dale Thompson (Benedictine Health System), Dr. Doug Wood (Mayo Clinic), Donna Zimmerman (for Mary Brainerd) (HealthPartners), Dr. Therese Zink (U of M).

1. Welcome to University of Minnesota – Duluth:

Chancellor Black welcomed the Task Force to Duluth and the University, remarking that the Task Force was taking on the toughest issues in the state – health care and costs. The Chancellor commented that the Task Force was building on decades of state reforms that had placed Minnesota among the highest quality states in the country. He noted that Duluth is the center for health care in northeast Minnesota, and that the UM-D medical school is a leader in training for rural practice.

Representative Huntley welcomed the Task Force to the district, noting the university was the leading institution in the country for training American Indian physicians. He noted that the work of this Task Force continues the efforts of the previous Health Care Transformation Task Force.

2. **Welcome, Updates, Review Minutes:** Commissioner Lucinda Jesson welcomed members, staff, and guests, commenting that the Lieutenant Governor provided a [Letter to the Task Force](#). There were no additions to the agenda; the [minutes from June 4th](#) were approved as written. She congratulated Essentia on their new agreement to cover Medicare patients with their Accountable Care Organization model. The Commissioner remarked that the Supreme Court ruling had made the Medicaid expansion optional for states, and asked if the Access work group would review the state's options and provide a recommendation to the full Task Force. Ralonda Mason, work group chair, agreed to look at the issue. Jesson noted that recommendations of the Exchange Advisory Task Force would be reviewed by this Task Force later in the fall. Commissioner Rothman offered to continue to report on the progress of the Exchange.

3. **Access Work Group preliminary recommendations:** Ralonda Mason presented the [preliminary recommendations](#) of the Access work group for input from the Task Force. The work group will return with revised recommendations in September. She noted that while the Medicaid expansion would cover the population with incomes up to 138% of the Federal Poverty Level (FPL), the Access work group focused on the population between 138% and 200%, a population partly covered by MNCare currently and may have health care and affordability needs beyond Exchange plans alone. She thanked the work group members, staff, and participants for their contributions. Mason noted that uninsurance a strong contributing factor to morbidity and death in the U.S. and that to improve the health of Minnesotans, we need to increase access to insurance, and ensure that the care people receive will meet their needs. Supplementary Material: [Health Insurance Coverage in Minnesota](#).

Topic #1: Essential Health Benefits

Main Points from Ralonda Mason

- Since the Task Force adopted recommendations regarding the EHB in March 2012, HHS has released additional guidance but not a final rule on EHB. More details are needed to determine which small group plan would be Minnesota's default for 2014-2016.

Task Force Member Discussion on Topic #1

- If we don't select a plan, Minnesota's essential health benefits for 2014-2016 will be based on the default plan. HHS regulations have stated that the default will be the largest plan in the small group market. The default plan would be augmented with other services to ensure that all ten coverage categories required by the ACA are included in the plan. There is an option to select a different plan later (after 2016).

Topic #2: Evaluate Coverage Options for Low-Income Minnesotans (138-205% FPL) & Not Covered by Medicaid in 2014

Main Points from Ralonda Mason:

- The work group agreed that coverage for this population in 2014 should be at least as comprehensive and affordable as MinnesotaCare.
- In 2014, Minnesota will have the option of covering adults (138 – 205% FPL) in the Exchange, supplementing Exchange plans with additional benefits and affordability support (Wrap Around option) at state cost, or creating a Minnesota-based plan for this population with 95% of the federal funding that would have been directed to this population in the Exchange (Basic Health Plan).
- The Exchange plans will offer tax credits for those 138-400% FPL to purchase commercial Exchange plans.
- **Recommendation for out-of-pocket costs for adults at 138-205% FPL:** Premiums should address identified affordability gaps in MNCare today. No premiums for those at 138%FPL-150%FPL. For those with incomes at 151-205% FPL, premiums should be based on a sliding fee schedule as follows: Start at \$0 at 150% FPL and increase in sliding scale up to current MNCare premium levels for these individuals at 205% FPL. Cost sharing for all income levels in this population should be nominal - no lower than MNCare levels without the hospital cap.
- **Preliminary benefits recommendation for adults at 138-205% FPL:** The work group reached consensus that MNCare benefit set (without the hospital cap and maintaining the model mental health benefit set) should be the baseline for coverage. Preventive health services should be covered at nominal or no cost.
- **Next steps:** Additional discussion will take place in the work group on other benefits for consideration. The group will also consider health care needs for those who will remain without insurance in 2014 and next steps on essential health benefits.

Discussion among Task Force members on Topic #2:

- With the Medicaid expansion, the feds will pay 100% of the cost up to 2016, then phasing down to 90%. The state costs for the 138 – 200% population will depend on the choices we make, including what would be covered in a basic health plan. Is there an unintended consequence to restricting the Medicaid programs?
- The MNCare package may not be adequate to improve health. If there is a decision to offer consistent benefits to all in the state, we will need to pay for that.

- We should not have copays for preventive and primary care. We should include mental health services such as in the Diamond Project. Increased primary care services can decrease specialty care costs by as much as 20%. We should also consider how the cost savings from improving the health care system (Care Integration/Payment Reform work group) can be redirected to provide better coverage for these populations.
- The next step is for the Exchange is to run the numbers on the criteria from the work group. The work group needed to share this information with the Task Force first.
- We need to evaluate the effect on churning and consistency of coverage. Ideally, this should be seamless for the patient and should prevent more expensive care later.
- Recommendations for the 138-205% population could allow for current (MNCare) benefit sets and full hospital coverage. We need to pick up the MNCare eligible but not enrolled population. Options are:
 - Tax credits for exchange plans – this would increase out-of-pocket costs.
 - Create a basic health plan modeled on MNCare and add full hospitalization.
 - Create a wrap-around policy using MNCare dollars.
- It would be helpful to see who is in the MA population, MNCare population, and Exchange population to see the overlap. What happens when the parts move?
- Is there a medical loss ratio difference between the basic health plan and commercial insurance? How much state money goes into medical care versus administrative costs?
- Think of the population by eligibility changes and processes. In the Exchange, we would not see as much churn. Think about the continuum from Medicaid – what income levels are churning now?
- The tools we have are benefit plan design, cost sharing, and administrative processes.

Public Comment on Access Work Group recommendations:

- **Stuart Hanson, MD:** Using the term “Basic” or “Essential” gives the connotation of “minimal” or “floor”; a better term is “Standard Health Plan” or “Standard Benefit Set.” This will be easier to promote to the public. High deductibles and copays have not been effective in reducing costs, and have resulted in delayed care at higher costs. The low-level Bronze Plan is inadequate and should not be offered.
- **Stacy Meis:** As a seasonal worker in Duluth, I have been fortunate to be on the MNCare program. The program helped me to get on my feet despite having arrived in Duluth pregnant, homeless, and suffering from two chronic and debilitating diseases. I am concerned that MNCare would disappear, and that I would have a high-deductible program on the Exchange. What may seem like a small change in a program could be a disaster to an individual. We need to work together as a state.

4. Break

- 5. Workforce Work Group updated recommendations:** Dr Therese Zink presented revised work group recommendations which incorporated feedback from the May Task Force meeting. She introduced the panel: Nitika Moibi (MDH), Mark Schoenbaum (MDH), Regina Wagner (DHS), and Bob Held (DHS). She noted that the work group members, agency staff and partners, had all contributed to development of the draft recommendations. Zink commented that in order to address the current need, it was time to be bold, and to move outside the box. Handouts: [Workforce Work Group Presentation](#), [Workforce and the Triple Aim](#), [Workforce Work Group Priority Recommendations](#).

Recommendation 1: Remove practice barriers for advanced practice nurses by adopting the Advanced Practice Registered Nursing (APRN) Consensus Model and enacting the APRN Model Act and Rules.

No Task Force discussion on #1.

Recommendation 2: Increase availability of mental health and substance abuse services through investments in the Mental Health and Substance Abuse Workforce. Regina Wagner noted that Screening, Brief Intervention, Referral to Treatment (SBIRT) has been expanded to the ER and primary clinics and is being expanded with a model similar to the Diamond project.

Discussion on #2:

- Are grants in 2A specific to mental health and substance abuse provider types? Answer: They are targeted to mental health and substance abuse professionals.
- There is a shortage of child psychiatrists. We need to direct funding to build capacity in underserved areas and diverse communities that are not currently being served. We should look at communities and see what's missing. Answer: Recommendation C looks at child and adolescent issues.
- Community mental health agencies do not have funding for clinical placements for paid internships. Answer: Although the report does not specifically address this issue, there is an opportunity to offer amendments and modify based on this feedback.

Recommendation 3: Increase the supply of primary care workforce and stabilize support for all health professions education by supporting existing health professions training sites and targeting new sites for primary care physicians, APRNs, physician assistants and pharmacists. Fund these efforts by restoring the 2011 cuts in funding and providing additional funds to the Medical Education and Research Costs (MERC) program.

No discussion on #3.

Recommendation 4: Increase the supply and improve the stability of the long term care workforce by increasing wages and benefits of direct care workers employed in nursing homes, in-home care, etc., as compared to counterparts working hospitals, ability to do some targeted career advancement.

Discussion on #4:

- All of this should be endorsed. The underlying demographics are scary. There is growing design of post-acute care adjacent to hospitals for patient acuity beyond the level of the skilled nursing facility.
- I strongly believe that we need to increase the long-term-care workforce. We need to make LTC part of Accountable Care Organizations. There is a lot to digest now, and we may need refinements.
- We need mechanisms for tentative approval, and look at this again when we see the total package.
- LTC is a big part of the Medical Assistance budget. There is turnover rates in nursing homes and now we are asking nursing homes to do more. We have to be willing to pay for outcomes.
- I support this overall, but need to think about it more.

- Consider what we want care to look like overall. True integration will save cost.
- Have other states looked at payment parity in terms of LTC reform?

Recommendation 5: Improve access to care in Greater Minnesota by supporting and expanding telehealth and related technology to improve quality and access and extend workforce capacity.

Discussion on #5:

- This will help to address patient issues, and lead to more timely and suitable care. Commissioner Rothman's staff has been very helpful as the work group has been looking at broadband.
- There needs to be a public-private partnership in rural MN.

Recommendation 6: Improve access to dental care by supporting start-up changes and practice redesign for dental therapists and advanced dental therapists; and support all state-level administrative actions to enable dental hygienists with a collaborative agreement with a dentist to perform oral examinations as part of child and teen checkups.

Discussion on #6:

- This puts resources into Advanced Dental Therapy (ADT) integration.
- It will improve access to dental care for children.
- DHS does not pay for certain services performed by dental hygienists, but the federal laws on this have changed to make that possible.
- Oral health is a huge issue in rural areas.
- We need to enable dental hygienists to bill for more services.
- Between the U of MN and Metro State, there are 20 ADT students. There is plenty of need for their services.
- Oral health contributes to total well-being.
- Access to dental care is crucial and undeliverable in low-income areas. It is important to increase access.

Recommendation 7: Increase the number of health professionals in underserved areas by restoring and increasing the state's Health Professional Loan Forgiveness Program beyond its pre-cut 2011 budget and opening the program to additional groups of health professionals.

Discussion on #7: This will increase access in rural areas.

Recommendation 8: Increase the supply of long term care workers by expanding the Minnesota FastTRAC (Training, Resources, and Credentialing) program that trains nontraditional adult learners

Discussion on #8: This will prepare non-traditional adult learners for health care jobs.

Recommendation 9: Increase diversity in the healthcare workforce by supporting a range of health professions diversity programs and helping foreign-certified physicians obtain Minnesota licensure and investing in recruiting diverse medical school candidates.

Discussion on #9: This will increase funds to improve competencies and mentorships, and grow interest in health careers.

Recommendation 10: Consider the impact of MN joining the Interstate Nurse Licensure

Compact, through establishing a stakeholder work group and conducting a study of relevant issues.

Discussion on #10:

- Consensus on the language of the recommendation was not reached.
- Stakeholder groups are close to agreement, and are willing to bring forth language for adoption.
- There are a set of issues around several issues. It is important to work through each issue one at a time. The licensure compact may or may not be the solution. The underlying problems still need to be addressed.
- The ACA is expanding the Medicaid population by 40%, but physicians are not accepting Medicaid payment levels now. We need to address this and the issue of having primary care providers take care of this population.
- This has been discussed by the Access work group in the context of provider reimbursement rates. There will be more discussion on the topic in September.

Public Comment on Workforce recommendations presentation:

- **Mike Mahoney, Essentia:** Essentia Health has a presence in four states, particularly in rural areas and now has an ACO. Nurses from Minnesota cannot call Wisconsin to consult with colleagues across state lines unless they are licensed in both states. Essentia strongly supports Minnesota becoming a member of the Interstate Nurse Licensure Compact.
- **Janet Silversmith, MMA:** The Minnesota Medical Association applauds the work of the Task Force and Work Groups to improve the capacity of the primary care workforce. The MMA generally supports the proposals, but asks the group to revisit recommendation 1 (Advances Practice Registered Nurses). This doesn't reflect the consensus of other health care providers, as it includes other nursing types, such as nurse anesthetists. The MMA urges revisiting the issue, and adopting recommendations approved in 2009 by the MN Workforce Study Group, including elimination of the prescribing agreement, and having APRN nurses practice in the context of collaborative care.
- **Shannon Cunningham, MN Nurses Association:** The compact is not the only possible solution. The Association is not opposed to studying the compact, and wants to ensure that the solution will protect both nurses and patients.
- **Louise Curnow, Physicians for a National Health Program:** Consider whether the proposed program will cover everyone with standardized coverage, regardless of income. The Bronze plan equals bankruptcy insurance. Consider appointing a work group to study the Lewin report on single payer, and present this to the Task Force.

Motion: Pete Benner moved to adopt recommendations 1-9 as working recommendations.

This was seconded by MayKao Hang.

Discussion:

- A friendly amendment was proposed to include recommendation 10 for study. This was not accepted.
- This is a working approval only. Final approval will be decided after all work group recommendations are received at the end of the process.

Vote: Unanimous to approve.

Motion: Ralonda Mason moved to adopt recommendation #10 separately for study, with

specific language to be refined when the stakeholder groups weigh in on how the study should be conducted. This was seconded.

Vote: Unanimous to approve.

6. **Exchange Update:** Commissioner Mike Rothman noted that this week Governor Dayton wrote a letter to Secretary Sebelius regarding Minnesota's work to stay on track with the 2013 ACA deadlines. The Exchange is completing the process of selecting an IT vendor. Key staff have met with HHS in Portland and are receiving technical assistance from the Robert Wood Johnson Foundation. The next Exchange Task Force meeting is on July 26 in Moorhead, from 1:00 – 3:00 p.m.

7. **Public Comment:**

- **Pastor David Tryggestad, Concordia Lutheran Church:** Several family members had significant access issues. He sees people on the edge all the time – we need to have enough indignation to make changes.
- **Michael Zdychnec:** Citizen engagement is key. We will be asking consumers to change their role in the health care system. Most consumers do not understand health care concepts. It's important to keep a consumer perspective.
- **Elizabeth Olson, CHUM:** The Citizen Solutions experience was enriching and empowering. It can be difficult for the average citizen to enter the conversation.
- **Vicky Sandville, MN Citizens Federation:** We should adopt a Basic Health Plan, increase federal financial support, and increase the value of health care coverage. MNCare was created because the private insurance market did not offer affordable coverage. The Exchange will not provide affordable coverage either.
- **Buddy Robinson, MN Citizens Federation:** The county-based purchasing that DHS contracts for the prepaid Medical Assistance program is excellent. We need a universal, statewide system.

- 8: **Next Steps:** Commissioner Jesson thanked the group assembled, and thanked the University of MN – Duluth for hosting the meeting. She noted that the next meeting will be in St. Cloud on August 6th.

The meeting was adjourned at 5:50 p.m.